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INTRODUCTORY REMARKS

Introductory Remarks. I

WILLIAM T. FRIEDEWALD, MD

National Heart, Lung, and Blood Institute, National Institutes of Health

I speak on behalf of the National Heart, Lung, and Blood Institute (NHLBI) when I say we are delighted to be a cosponsor for this important and timely Bethesda Conference. As we have learned more about the problems of cardiovascular disease in the elderly, the issues have become more critical and now reflect an area of special research interest for the NHLBI. The National Center for Health Statistics (NCHS) estimated that in 1984 there were approximately 26 million people in the United States aged ≥65 years and living independently, that is, outside nursing homes or other similar facilities. Eight percent of this elderly population were black. Most were women; 59% in the age group 65 to 74 years and up to 71% in the age group ≥85 years were women. In addition, the size of our elderly population is growing dramatically, with an estimated increase of 20% during the next decade alone.

Currently, more than half of the patients in hospitals each year who are diagnosed as having an acute myocardial infarction are ≥65 years of age. This fraction can be expected to increase significantly during the 1990s. Even though overall coronary heart disease mortality rates in the United States declined dramatically during the 1970s, the rates for those aged >65 years have not shown the high rates of decline observed for younger members of our society.

NHLBI-sponsored and cosponsored programs such as the Systolic Hypertension in the Elderly Program, the Beta-blocker Heart Attack Trial, the Framingham Heart Study and the Coronary Artery Surgery Study all relate to the important topic of this conference. More directly relevant, however, is a working conference held last September by the NHLBI on the topic of Recognition and Management of Coronary Heart Disease in the Elderly (1). That conference came to several important conclusions and recommendations. Briefly, it was felt that, although the U.S. population aged ≥65 years encompasses the majority of patients with coronary heart disease, scientific information regarding the recognition of and current treatment approaches to the elderly coronary patient is inadequate or lacking. It was also considered inappropriate to uncritically extrapolate information obtained from younger persons to an elderly population, who as a group are remarkably heterogeneous with regard to their health and life-style characteristics. The elderly are likely to be at increased risk for complications associated with various diagnostic and therapeutic procedures and often, appropriately, have quite different expectations concerning the outcomes of their illness. It was also felt that more basic health information, including data on prevention, diagnosis and treatment of coronary heart disease, was needed about this rapidly increasing segment of our society.

Additional issues raised at that NHLBI conference were: whether the traditional risk factors for coronary heart disease determined in younger populations have similar predictive power in the elderly; whether nutritional and exercise guidelines should differ from those for younger people; whether the benefit conveyed by drugs used to treat coronary heart disease are of similar value in the aged as in the young; whether the quality of life is not more important than the additional length of life in the elderly; and whether one can or should justify upper age limits for such therapeutic procedures as coronary bypass surgery or percutaneous transluminal coronary angioplasty, or for various preventive approaches appropriate with younger populations. As a consequence of this working conference, as well as related activities, the NHLBI sees a continuing need to initiate and support research in coronary heart disease in the elderly. We now look forward with excitement and interest to the deliberations and recommendations of this broader scope Bethesda Conference.

Reference

1. Wenger NK, Furberg CD, Pitt E (eds.). Coronary heart disease in the elderly. New York: Elsevier, 1986.

Introductory Remarks. II

LOT B. PAGE, MD

National Institute on Aging, National Institutes of Health

I am happy to greet you on behalf of the National Institute on Aging and its Director, Dr. T. Franklin Williams. It is very appropriate and timely that "Cardiovascular Disease in the Elderly" is the subject of this year's Bethesda Conference. The United States, and indeed the entire industrialized world, is experiencing a demographic explosion in the upper decades of age. The rapid current increase in numbers of older persons in society is unprecedented in history and

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is progressively accelerating. Well over half of all persons in the history of the world who have ever reached the age of 65 years are alive today.

Latest figures for the U.S. show that life expectancy for children born in the early 1980s is 70.8 years for males and 78.2 years for females. For persons who reached the age of 65 in 1985, an average life expectancy of 15.1 additional years is predicted for men and 19.5 additional years for women.

In 1985 there were 28.6 million persons aged ≥65 years, representing 11.9% of the U.S. population. Projections for future demographic trends depend on varying assumptions. "Mid-range" projections, made in 1984, indicate that in the year 2030 there will be 34.9 million persons aged ≥65 years, representing 21.1% of the U.S. population or almost double the present proportion. The fastest growing segment of our population are those aged ≥85 years. At present there are approximately 2.7 million of these "oldest-old," and they are projected to increase by nearly sixfold, reaching almost 16 million by the year 2030.

These demographic shifts are truly dramatic and the consequences to our society will be profound. Despite general downward trends in cardiovascular mortality, by far the leading cause of death and disability in the elderly is cardiovascular disease, and the cardiovascular risk increases steadily with age.

Life inevitably ends in death. As physicians, our goal for the elderly should not be the indefinite extension of life; for this group, the prevention of enfeeblement, disability and dependence is the dominant health objective. As a new recruit to the field of aging research, I look forward with great interest to participating with you in discussion of these important topics.

Introductory Remarks. III

NANETTE K. WENGER, MD, FACC

Chair, 18th Bethesda Conference

The elderly represent the most rapidly growing group in the nation; about 5,500 individuals reach their 65th birthday each day. The preponderance of our elderly population is reasonably healthy, lives independently in the community and is adequately functional—despite a greater than 80% prevalence of at least one chronic illness. Many elderly persons look and feel younger than their chronologic age. Some continue at remunerative work and most look forward to an extended and active retirement. Thus, preventive efforts are most appropriate to include in medical planning.

The elderly are, however, a highly heterogeneous group in all respects except their chronologic age. Chronologic age is a poor predictor of functional capability. As Pascal stated, "Old age is just a time that is farther from the beginning and nearer to the end."

Nevertheless, the 12% of the population >65 years of age currently uses 30% of our national health resources. Some 1.3 million elderly persons reside in nursing homes, at an annual cost exceeding $13 billion. The elderly are also disproportionately high consumers of drugs, with this 12% of the population taking 25% of all drugs. Because drug interactions increase logarithmically and are further accentuated by the multisystem decrease in function with aging, appropriate pharmacotherapy, in appropriate dosage, must be prescribed with care.

Our goals for this Conference are multiple and our target audiences varied. Many of our conclusions and recommendations are designed to help physicians and other health professionals who care for elderly patients with cardiac disease; many are designed for elderly cardiac patients themselves; and many are designed for society: both the general public, including the elderly, and society's elected representatives, the individuals who formulate and promulgate public policy.

In a recent article in the *Journal of the American Geriatric Society* (1) advice was given that the physician "who voluntarily undertakes to deliver services to an older population also voluntarily undertakes, explicitly or implicitly, to develop and maintain a significant data base on the physical, mental, psychologic, social, economic, legal and spiritual realities of aging in contemporary America."

Thus, at this Conference, to assemble a contemporary data base on cardiovascular disease in the elderly for the medical community, we plan to identify the features of biologic aging that are associated with the cardiovascular system as contrasted with those that are associated with disease. For a number of specific cardiovascular disorders and their manifestations we plan to define those characteristics unique to the elderly and to provide reasonable direction for the appropriate recognition and management of specific cardiovascular illnesses. Equally important will be delineation of the information that is yet needed to provide quality cardiovascular care for elderly persons, information that will likely require both basic and clinical research. So many decisions made in the care of elderly patients are based on data extrapolated from younger populations. We further hope to identify those clinical features and approaches that suggest or increase the likelihood of a favorable outcome.

But medical care does not take place in a vacuum. On the one hand, we are the beneficiaries of unprecedented scientific developments, with major advances made in health